2004 HEALTH INSURANCE CHECKLIST

NAME – LAST	FIRST	MIDDLE INITIAL	SOCIAL SECURITY NO.

AGENCY NAME	HIRE DATE MO DAY YR	WORK PHONE ( )	CO. OF RESIDENCE	COMPANY NUMBER

Following is a list of your rights and responsibilities regarding the Public Employee Health Insurance Program. Read this form carefully and make sure you understand each item. You may direct your questions to the Insurance Coordinator or the Office of Public Employee Health Insurance.

As a new employee I understand:

___ I have thirty (30) days from my date of employment, or _____ (date specified by your employer) in which to enroll in one of the available health insurance plans.

___ I must submit all applications for health insurance (or waiver) and Flexible Spending Accounts to my agency's Insurance Coordinator.

___ I must choose a plan that is available in the county where I live, work or that is designated as a Contiguous county for purposes of health insurance only. (See Availability Chart in your *Health Insurance Handbook*. If I live outside the Commonwealth of Kentucky, I must choose a plan that is available in the county where I work.

___ I will be subject to a one time twelve (12) month waiting period for pre-existing conditions unless I have had prior creditable coverage for at least twelve (12) months and there has been no more than a sixty-three (63) consecutive day break in coverage between the termination of that coverage and the effective date of my coverage with the Public Employee Health Insurance Program. Any prior period of coverage that is less than twelve (12) months can be applied against the pre-existing condition waiting period. A comparison chart of the health insurance plans (PPO, HMO, POS and EPO) is printed in the *Health Insurance Handbook.*

___ I must indicate my level of coverage on my application.

- SINGLE – Employee only
- PARENT PLUS – Employee and Dependent Child(ren)
- COUPLE – Employee and Spouse
- FAMILY – Employee, Spouse, and Dependent Child(ren)

___ I have confirmed the availability of my payment options with my Insurance Coordinator.

- MONTHLY – Health Insurance premium is deducted from the last paycheck of the month.
- TWICE MONTHLY – Health Insurance premium is deducted equally from both paychecks. **If I fail to choose a payment option, the premiums will be deducted twice monthly, if available.**
- CROSS-REFERENCE – The participating employer contribution for the Health Insurance Premium for both eligible spouses is applied toward family or couple coverage, with the remaining premium deducted equally from each spouse's paycheck.
  - NOTE: The husband and wife must be eligible for the employer contribution in the Public Employee Health Insurance Program.
  - Certain requirements must be met in order to cross-reference. See your *Health Insurance Handbook* for a listing of those requirements.

___ Each Fall there is a defined Open Enrollment Period for health insurance that provides me the opportunity to make ANY type of change in my health insurance coverage that I wish to make. **NOTE: CHILDREN COVERED BY COURT ORDER OR ADMINISTRATIVE ORDER MAY NOT BE DROPPED FROM MY INSURANCE COVERAGE EXCEPT BY A SUBSEQUENT COURT ORDER OR ADMINISTRATIVE ORDER.**

___ Outside of Open Enrollment I will only be allowed to add or drop family members from my current plan and, in appropriate circumstances, change plans **within thirty (30) days of a Qualifying Event or thirty (30) to one-hundred twenty (120) days for newborns (refer to *Health Insurance Handbook* for additional information on adding newborn)**. A list of Qualifying Events is printed in the *Health Insurance Handbook*.

___ It is my responsibility to contact my Agency's Insurance Coordinator no later than thirty (30) days of any event that may affect my coverage (See your Insurance Coordinator for a complete list of Qualifying Events).

___ The State offers a Premium Conversion program that allows me to pay my portion of the health insurance premium with pre-tax dollars. I understand that I will automatically be enrolled in the program by virtue of enrolling in health insurance, unless I sign a cancellation form.

___ My coverage will become **effective** on the first day of the second month following my employment or on a date stipulated by my employer.

___ If, sometime after my health insurance becomes effective, I and/or my covered dependents lose coverage due to termination of employment, divorce, or any other COBRA Qualifying Event, I/we have the right to continue health insurance benefits at my own expense under COBRA (see Initial Notice Memorandum on page 4-4).

___ If I decide that I DO NOT want the state-sponsored health insurance at this time, I can waive (decline) coverage by completing the appropriate sections of the application. If I waive coverage because I am covered under my spouse's plan, I will be allowed to enroll in a plan through the Public Employee Health Insurance Program if one of the following occurs:

1. my spouse's employer group health insurance terminates;
2. loss of eligibility;
3. the spouse's employer ceases contributing to the plan; or
4. if COBRA coverage is involved, the COBRA coverage expires.

Check with your spouse's health plan before waiving coverage. Some companies will not cover you if you are eligible for health benefits through your own employer.

___ I may have the opportunity to enroll in the Flexible Spending Account programs, if applicable, no later than thirty (30) days of my date of employment. I have obtained the appropriate Flexible Spending Account information and application from my Insurance Coordinator.

___ I may contribute my own money into either the Medical or Dependent Care Flexible Spending Account. Once I have directed money into the Health Care FSA, changes are permitted for a HIPAA Special Enrollment Right or a Change in Status if the change is requested no later than thirty (30) days of the event giving rise to that right or change**.** Changes are allowed to the Dependent Care FSA with an approved Change in Status.

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___ Have you worked for any other agency participating in the Public Employee Health Insurance Program within the last sixty-three (63) days?
Yes ❒ No ❒
If yes, please give name of agency and date terminated or transferred.

_____/_____/_____
Agency Date of Termination or Transfer

___ Are you retired from a state-sponsored retirement system?
Yes ❒ No ❒

If yes, please specify which system:

_____ Kentucky Retirement System
_____ • County Employees Retirement System
_____ • Kentucky Employees Retirement System
_____ • State Police Retirement System
_____ Kentucky Teachers' Retirement System
_____ Judicial Retirement Plan
_____ Legislators Retirement Plan

I acknowledge that I have received copies of:
_____*Health Insurance Handbook*
_____Health Insurance Application
_____Flexible Spending Account booklet, if applicable
_____Flexible Spending Account Application, if applicable
_____Initial COBRA letter
_____Memorandum regarding Notice of Special Enrollment Rights and Women's Health and Cancer Right Act
_____Other _____

I certify that I have had my Health Insurance and Flexible Spending Account benefits explained and that I understand the benefits and my responsibilities.

_____ _____ _____
Employee Signature **Date** **Agency Representative**

EMPLOYEE SHOULD KEEP THE ORIGINAL NOTICE FOR HIS/HER RECORDS.

INSURANCE COORDINATOR SHOULD KEEP A COPY IN THE EMPLOYEE'S PERSONNEL FILE